

**County-Based Juvenile Justice Alternatives:  
Financing Options**

**The Jane Addams Juvenile Court Foundation  
Policy Discussion Paper**

Prepared by  
The Youth Campus Research Center

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# I. EXECUTIVE SUMMARY

There is a problem. More youth are being presented in delinquency courts. These youth are also presenting more complicated behavioral problems. This has placed increasing demands on already limited County funds. In Illinois, the counties experiencing the most pressure are: Cook, the Collar Counties, and rural counties. This is a unique alignment for a shared problem in the Illinois political landscape.

There are solutions. The research in juvenile justice describes structures, methods, and clinical approaches that are proven successful in treating juvenile offenders. This knowledge base creates a platform for not just more, but better interventions. There are funds to move forward. Federal funds are available and appropriate for the financing of a system of treatment interventions for young offenders. Illinois is well-positioned to implement a financing strategy which matches county funds with federal funds to create new services. This solution does not place any additional burden on Illinois taxpayers and, in fact, returns federal tax dollars to Illinois.

This paper provides: a review of the epidemiology and services research in juvenile justice, issues with current Illinois law, a description of the federal programs that can be accessed to develop new community services, and a proposed process to achieve this aim.

## Research Findings

A wide range of juvenile justice experience and research during the 1990s has developed a clear picture of the challenges and opportunities currently before Illinois' juvenile courts and communities.

- **Epidemiology studies** – nationally and in Illinois – show that from 1993 to 1999, juvenile arrests declined; however, in Illinois, from 1990 to 1999 there was also an across-the-board increase in the rate of arrests that resulted in court-involvement and admissions to juvenile detention centers. This higher rate of penetration into the system may be attributed to two factors. First, the passage of P.A. 90-590 and the subsequent shift from *parens patriae* to a principle of 'balanced and restorative justice'

impacted local practice. Secondly, juvenile justice professionals are seeing more complex presenting problems of juvenile offenders. This is confirmed in recent descriptive research that demonstrates the empirical link between mental health needs and delinquency. Presentation to the court is an attempt to respond to these youth.

- A large body of **services research** supported by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has been able to clearly define the required structure and elements of an effective juvenile justice system.<sup>i</sup> This structural and tactical model has broad acceptance among public and private sector experts at the federal, state, and county levels. This model, in fact, forms the basis for current Illinois Department of Corrections planning activities and has strong face validity in among Illinois policy makers. This clinical research has also described models for treatment that induce positive changes in youth behavior, values, skills, and personal goals. These studies also define a role for the juvenile justice system in providing sanctions in conjunction with the delivery of clinically/psychologically appropriate treatment services in a variety of settings.<sup>ii</sup>

Despite the clearly defined demand and broadly disseminated knowledge on effective solutions, Illinois' local juvenile judges and communities have few dispositional alternatives. In many communities, the choice is incarceration or nothing. The only barrier to crafting effective local alternatives is financing.

This lack of funds to support rehabilitative placements, services and supports for juvenile offenders is not a new problem in Illinois. There are long-standing local issues related to financing these needed services; neither county nor State taxpayers are prepared to fund these alternatives. In some rare cases, this is related to local mores that are more punitive than rehabilitative. The fact is, however, that there has not been much public debate. Over time, Illinois has been stuck in a dilemma as both the State and local jurisdictions attempted to achieve 'cost-shifting' to the other.

### Federal Programs

There is, however, an opportunity to break this logjam through to access federal funds to support the development of local alternatives to detention. The steps involved in this process include: a) legislative change; b) regulatory amendment; c) design and execution of well-structured intergovernmental agreements; and d) establishment of billing and federal claiming systems.

There are two sources of federal funds that are available to support local juvenile justice placements and services. These federal programs, their benefits, and requirements are fully described later in this paper. In summary, they are:

- **Title IV-E** which provides a 50% match for local funds to support substitute care, case management, and the administrative activity required to support a substitute care system. Much more importantly, Title IV-E eligibility confers automatic eligibility for Medicaid. Medicaid can be significant source of payment for mental health and other support services.
- **Medicaid Rehab/Clinic Option** which provides a 50% match of local funds for mental health services in communities, either in clinics or in-home. This option can support in-home respite and other services that respond to the need for community safety in alternative dispositions. In addition, the **Medicaid Targeted Case Management** program finances cross-system case management.

The Medicaid eligibility conferred by 'foster care' status can also increase access to health, mental health or substance abuse treatment for youthful offenders. The relationship of these programs and their potential to support county-based juvenile justice placements and services is illustrated on the following page.

Juvenile Justice Placements/Services	Potential Federal Funding
Secure Detention or Secure Residential Placement	Medicaid Rehab/Clinic Option
<b>Day Treatment and Day Release</b>	<b>Medicaid and Title IV-E for non-secure group homes or foster care</b>
<b>Community Reintegration or Deflection including:</b>  <b>Community Supervision and Advocacy Services</b> Routine Parole Supervision <b>Discharge and Follow-up Evaluation</b>	<b>Title IV-E for non-secure group homes or foster care</b> <b>Medicaid/Targeted Case Mgmt</b>  n/a <b>Medicaid for eligible clients</b>

These funds go largely untapped for juvenile justice in Illinois – with the exception of a small Cook County Medicaid pilot – despite the fact that other jurisdictions have successfully demonstrated that counties can access these federal funds for juvenile justice. These financing plans are cost neutral to the State and counties and provide for the substantial return of federal tax dollars to local communities. There are no federal policy or regulatory bars to implementing a comprehensive financing strategy – comprised of existing local funds and new federal funds -- to create new community alternatives for use by the juvenile court.

### Summary

Illinois is at a watershed in juvenile justice reforms. Juvenile Court judges, court professionals, clinicians and researchers are examining best practice models. Illinois has a proven track record in national leadership in juvenile justice and a broad group of stakeholders with diverse expertise and skills. The Jane Addams Juvenile Justice Foundation is prepared to convene Illinois policy leadership to convene experts and to facilitate a process to craft an policy, financing and program approaches to benefit Illinois' youth, families, providers, and taxpayers. Together we can define the common ground for creating a comprehensive justice strategy for youthful offenders and remove long-standing financing barriers.

## II. RESEARCH FINDINGS

### Epidemiology

The Illinois Juvenile Justice Reform Act, P.A. 90-590, reflects a shift in Illinois historic *parens patrie* stance to a principle of ‘balanced and restorative justice.’ which asks the court to consider the victim and the community in addition to the rehabilitative needs of the youth. While the implementation of the Juvenile Justice Reform Act reflects the popular view of juvenile justice, it places increasing demand on already stressed county resources. A very recent trend analysis of activity in Illinois juvenile justices system included data that suggest an overall decrease in number of arrests while the trend toward deeper penetration the juvenile justice system continues an upswing.<sup>iii</sup> These data include evidence of more demand on the courts, changed characteristics of the youth, and more complex risk management decisions. For example, in Illinois we have seen:

- a 300% increase in drug arrests from 1990 to 1999;
- increases in delinquency petitions outside of Cook County, particularly in rural counties which represent 32 of the 34 counties with the highest petition rates;
- a larger proportion of delinquency petitions adjudicated, in Cook County the rate increased from 33% to 50% from 1995 to 1998 and all other urban counties had similar experience;<sup>1</sup>
- from 1995 to 1998 admission to temporary detention centers increased statewide, the rural counties experienced a 57% increase in admissions;
- for the same period, admissions of youth to the Department of Corrections increased 100%, this trend toward commitment to DOC was true in all regions, except the collar counties.

So, while Cook County reports declines from all-time highs in both filing of delinquency petitions and admissions to juvenile detention centers, demand for court services continues to be high in Cook, the Collar Counties, and in rural counties. The unusual

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<sup>1</sup> Cook County reports that both the adjudication of petitions and admissions to temporary detention are down in 2000 and 2001.

alignment of the exact same need in these otherwise disparate counties can create a powerful coalition for change.

The Illinois Juvenile Justice Reform Act of 1998 (now P.A. 90-590) reflects a shift from Illinois historic *parens patrie* to a principle of 'balanced and restorative justice' which asks the court to consider the victim and the community in addition to the rehabilitative needs of the youth. The implementation of this Juvenile Justice Reform Act reflects the currently popular view of juvenile justice, but it places increasing demand on already stressed county budgets. These data support the needs for increased alternatives for disposition.

More importantly, the clinical epidemiology establishes the need for treatment and support services for youth with serious emotional disturbance who are involved in the juvenile justice system. Further, this research describes systems and clinical models that produce good outcomes for these youth.

A recent study of Illinois youth paper provides an overview of the literature that provides the empirical link between mental health needs and delinquency.<sup>iv</sup> This includes such studies as:

- Steiner & Cauffman, 1998 – showing that a large percentage of youth in the juvenile justice system have mental health needs
- Stiffman, Chen, Elze, Dore, Cheng, 1997 – reporting the juvenile justice providers report that their clients have significant mental health needs
- Timmons-Mitchell, Brown, Schultz, Webster, Underwood, & Semple, 1997 –reporting, in a limited epidemiology study, that over 50% of the youth in detention have diagnosable psychiatric disorders
- Weirson, Forehand, & Frame, 1992 – suggesting, as one of several studies, similarities between youth in the juvenile justice system and youth served in the public mental health system
- Vander Stoep, Even, & Taub, 1997 – documenting that youth served in the public mental health system are involved in the juvenile justice system at a rate three times that of the general population

This body of literature – in addition to consistently demonstrating the link between delinquent behavior and psychological disorders – also shows that multi-problem youth are identified and served in a wide variety of settings. In Illinois, this is driven more by what services are locally available than by a rational system for intervention.

Additionally, the types of mental health needs in the juvenile justice population are variable. While there are no established, stable prevalence estimates, a meta-analysis of small prevalence studies reported the following ranges of diagnosable mental health problems in this population.<sup>v</sup>

Mental Health Status	Estimated Prevalence in Juvenile Justice Population
Conduct disorder	50% to 90%
Substance abuse	25% to 50%
Personality disorder	2% to 46%
Psychotic disorders	1% to 6%
Affective disorders	32% to 78%
Anxiety disorders	6% to 41%

This same study of Illinois juvenile offenders suggests that serious emotional disturbance is a predictor for placement in a restricted setting. For juvenile offenders, in community settings 50% of youth demonstrated a level of need consistent with a Serious Emotional Disorder (SED). While in corrections 66% of youth demonstrated this level of need; and in residential treatment centers nearly 100% of youth exhibited this level of need. A further exploration in the same study identified the risks associated with increased likelihood of expensive institutional placement. These were the:

- clinical needs of the youth (e.g., greater elopement risk, greater peer dysfunction, poorer adjustment to trauma or abuse, or more multi-system needs)
- behavioral risk of the youth (e.g., greater elopement risk)
- caregiver knowledge and capacity

There is a clear and pressing need for the juvenile justice system to make dispositions which respond to *clinical problems, behavioral risk, and caregiver capacity* as part of balanced and restorative justice.

## Services Research

Part of the equation of managing clinical, risk and caregiver capacity is developing community services and supports. Fortunately, the juvenile justice field has developed a knowledge base – largely through a long-term, federal investment in research – which describe the specific requirements of an effective approach to treating and managing the juvenile offender work. This work can shape the performance expectations set forth in the intergovernmental agreements.

*Outcomes.* There are effective models for correctional treatment. Treatment can induce positive changes in youth behavior, values, skills, and personal goals.<sup>vi</sup> This suggests that the intergovernmental agreement include provisions for renewal based on client outcomes.

*Sanctions.* Delivery of clinically/psychologically appropriate treatment services in a variety of settings can be established by criminal sanction. The judicial determination required under Title IV-E supports this aim.

*Youth and Family Focused.* Successful services are sensitive to risk and need and are responsive to individuals and family and community context<sup>vii</sup> This allows for design of county-based system which are based on demand, current capacity (supply), and community mores and can guide local needs-based planning.

*Settings.* Both State and federal models envision a continuum of modalities for supervision and services delivery. These components are modeled after the OJJDP recommended five phase system of: a) residential treatment; b) day treatment; c) outreach and tracking (reintegration); d) reduced supervision (transition); and e) discharge and follow-up.<sup>viii</sup>

*Methods.* Methods for service delivery– *regardless of setting* –included five components: 1) risk assessment, classification of need, and targeting to guide supervision decision-making (i.e., level of restrictiveness and strategic interventions to manage risk); 2) responsive individual case planning across multiple life domains in a family/community context and cross system case management; 3) surveillance

appropriate to the setting along with the services; 4) clear incentives and graduated consequences to leverage change; and 5) linkages with community resources and networks for direct and brokered health, mental health, educational/employment, family and social services including basic needs and recreation/leisure activities.<sup>ix</sup> Counties may include each of these components in their local systems of intervention and services.

*Practice Expectations.* In any of these program settings, successful interventions include: a) progressive decreases from an initial high-level of external control to increased youth responsibility and control; b) individualized case plans which are continuously monitored; c) attention to developing attachments between the youth and his peers, adults, and other community groups and institutions; d) active teaching of social/interpersonal skills; e) development of life skills; f) education and employment opportunities which offer short and long term reward; g) risk management; and h) reliable rewards and sanctions. This set of expectations can guide the selection of providers for residential or community-based services.

*Risk Assessment.* In the area of risk assessment, an actuarial model is suggested with a commitment to more intensive services and supervision for higher risk youth.<sup>x</sup> In the area of assessment and case planning, a model based on both strengths and needs is recommended. The assessment and planning process should include the following characteristics: a) uniform attention to key life areas with a focus on strengths; b) clearly defined priority and intensity of the service delivery strategy; c) a defined basis for periodic reassessment and evaluation of progress; d) monitoring and evaluation conducted in an information system.<sup>xi</sup> The strengths based model is based on setting and meeting concrete goals which is consistent with compliance-driven decision making' in juvenile justice.<sup>xii</sup> The strengths based model is also a shift in that it recognizes that a youth and his family have strengths and past successes which can support the rehabilitative plan.<sup>xiii</sup>

A particularly important development in this area is the "Clinical Evaluation and Services Initiative" under the leadership of Honorable Donald P. O'Connell, Chief Judge, Cook County. Under this plan, an organized, rational system in the court will identify need and control access to services.

The recommended methods, settings, and practice guidance are consistent with Title IV-E and the Medicaid Rehab/Clinic and Targeted Case Management models. This alignment creates an opportunity for increased federal financial participation in Illinois' correctional system for youth. It is important that all stakeholders understand the congruence between recommended best practices and federal program options.

The table below describes the clinical services eligible for matching federal funds under Medicaid.

<b>Medicaid Rehabilitation/Clinic Options</b>	<b>Medicaid Targeted Case Management</b>
Finances <b>services</b> , including	finances <b>case management</b> , including
<p><b>CLINIC SERVICES</b>            Screening, diagnosis and assessment            Testing            Psychotherapy (ind, family, group)            Prescriptions and medication monitoring            Somatic treatments            partial hospitalization            emergency care            consultation and education</p> <p><b>COMMUNITY SERVICES</b>            day treatment            in-home services            collateral services            therapeutic foster care            early intervention services            crisis programs            some residential services</p>	<p><b>CASE MANAGEMENT ACTIVITIES</b>            comprehensive assessment            plan of care development            locating/arranging/referring for services            ensuring that services are received            monitoring and reevaluating the plan of care            completing the case record            assisting in obtaining collateral services            advocacy            integration of services            assisting/training building community supports            24-hour crisis response            collateral contacts            problem-solving            transition linkage and referral            face-to-face contact with youth and collaterals</p>

This alignment creates an opportunity to develop a county/federal financing strategy for Illinois' youth with serious emotional disturbance who are also involved with the juvenile court.

### III. CURRENT ILLINOIS LAW

There is also an argument that the provisions of the Illinois Juvenile Court Act<sup>xiv</sup> cannot be fully exercised by the judiciary due to the effects of poverty or direct financial constraints. According to current Illinois law, a juvenile court judge has a variety of dispositions available, including:

- Probation or conditional discharge
- Placement with someone other than the parent, guardian, or legal custodian
- Drug or alcohol treatment
- Commitment to DCFS for juveniles 12 years or younger
- Placement in a juvenile detention center for up to 30 days, if 10 years or younger
- Partial or complete emancipation<sup>2</sup>
- Restitution
- Commitment to the Juvenile Division of DOC (if 13 years or older)
- Suspension of driving privileges
- School or training
- Medical testing for sexually transmitted disease (for adjudicated sex offenses)

Governor Jim Edgar confirmed the importance of judicial discretion in his amendatory veto. Consistent with legal best thinking -- and Title IV-E policy -- this veto focused on "giving judges continued discretion in considering the best interests of minors at certain points in delinquency proceedings."<sup>xv</sup> This amendment was accepted by the Illinois General Assembly and the Juvenile Justice Reform Act of 1998 (P.A. 90-590) took effect on January 1, 1999. This wide array of judicial options, however, may be illusory. There are several practical issues that limit judicial options at disposition.

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<sup>2</sup> New federal legislation to support independent living for former wards of the state can offer concrete supports to youth who are emancipated by the court. In addition, this federal act extends Medicaid eligibility for persons ages 18 to 21. To the extent that Title IV-E and Medicaid are used in combination for juvenile justice, this Medicaid eligibility can serve as an important source of funding for mental health services.

First, judges must consider risk management. If a family does not step forward, or the family is judged to have insufficient capacity to manage the risk, the youth is likely to be placed in a secure facility<sup>xvi</sup>. The question of the family's capacity to manage risk may, in fact, be a product of poverty, for example

- both parents working, a single working parent, or a parent with a disability
- social isolation without a supportive network of family and friends

As a result of factors like these – unlike more subtle and legitimate judgements about parental capacity -- in-home supervision and supports may not be viable. There is, then, a question of social justice where poverty and its effects place a youthful offender on track for secure detention when more economically privileged youth may receive less harsh alternative dispositions.

Secondly, where the family can manage behavioral risk, judicial discretion may be limited by the lack of accessible and appropriate community services and supports. In poor communities, there simply may not be clinics with the capacity to serve youth. Where there is capacity for youth treatment, a youth with no insurance may not have access to these services. There is also, for the courts, a question of capability. Local providers may not have expertise with the juvenile justice population and the requirements of the court. Referral to these providers is a risky proposition. An important component of local capacity building for the juvenile justice system as part of 'balanced and restorative justice' is increasing the confidence of the courts through concrete improvements in provider capability.

Thirdly, out of home placement is limited by the county budget. State policy decisions have had an adverse effect on access to foster care and residential placement. The purchasing power of counties is seriously degraded.

There is a clear and pressing need for the juvenile justice system to make dispositions that manage clinical problems, behavioral risk, and caregiver capacity.

The use of Title IV-E and Medicaid Rehab/Clinic Option programs can remediate these problems and make real the promise of judicial discretion. Through these programs, counties can form a pact with the State that:

- increases county purchasing power for in-home and out of home supervision and services
- increases the provider pool with contractual stipulations requiring knowledge of juvenile justice issues and court requirements
- increases the insurance coverage for clinical treatment youthful offenders through Medicaid

All of these improvements are in the interests of children and families, the judiciary, and local governments. These benefits can accrue at no additional cost to Illinois taxpayers.

## **IV. BACKGROUND ON FEDERAL PROGRAMS**

This section briefly describes: 1) the targeted federal programs, along with federal restrictions on their use; 2) the experience in Illinois or other jurisdictions; and 3) state issues or concerns. The key to the success of this effort is developing a complete understanding of the policy and political climate at the county, state, and federal level.

The benefits of a federal claiming strategy are clear. For counties, the primary benefit of a new federal claiming strategy is the creation of a new, locally managed pool of funds to finance services and placements. With these resources, judges and court personnel can craft community alternatives to detention/correctional placement without driving up either state or county costs and passing those costs to Illinois taxpayers. There are two federal programs to finance juvenile justice services and supports: Title IV-E and Medicaid. Title IV-E funds substitute care and confers Medicaid eligibility. Then, under Medicaid -- both the Rehab/Clinic Option and the Medicaid Targeted Case Management Program -- can be used to develop alternative services and supports at the local level.

In fact, early on DCFS recognized the opportunity to treat serious emotional disturbance among children in its care and custody by combining Title IV-E and Medicaid. Over time, DCFS had become the major provider of clinical services to as the default system for placement for children serious problems. Even so, the primary source of federal support for foster care and residential services (Title IV-E) paid only for case management services and maintenance costs -- it did not support the clinical elements residential or foster care treatment services. However, Title IV-E did confer Medicaid eligibility on all foster children.

By integrating Medicaid programs into the foster care continuum, the quality and intensity of the service offerings were substantially upgraded -- and more expensive. This opportunity was twofold: accessing new financing and setting minimum provider standards. Rule 132 provided way to leverage the state dollars for clinical services for children presenting increasingly complex clinical needs. Also importantly, provider

certification under Rule 132 would cause providers who chose to participate to restructure programs, upgrade clinical staff, and introduce new clinical procedures.

The current structured limitation of Medicaid and Title IV-E match has had an adverse impact on juvenile justice programs in Illinois. This solution for the child welfare and mental health systems started a chain reaction in juvenile justice that has left the field worse off. The very strategy that intensified the clinical capacity for wards of the State and other poor children at no cost to the State drove up the costs of care at the county level and led to unexpected pressures on the juvenile justice system. As county costs increased, resources for alternative dispositions were reduced. Further, the transactions between the State and the counties on this issue exacerbated long-standing disjoints between county and state responses to youthful offenders and further confused the technical issues of juvenile justice participation in federal programs

## **Substitute Care/ Title IV-E**

### **1. Federal Requirements**

*Description.* Title IV-E is the federal program to support foster care or out-of-home placement. The Administration for Children Youth and Families (ACYF) reimburses the State for 50% of the costs of substitute care – room, board, case management and management of the home – on a per diem basis.

*Benefits.* There are four applications of Title IV-E to the juvenile justice population. According to federal requirements, Title IV-E funds can:

- support the use of substitute care as an alternative to detention or commitment to the Illinois Department of Corrections
- reduce the cost of group home and institutional placements for counties
- confer Medicaid eligibility as part of ‘foster care’ status
- confer extended Medicaid benefits to ‘former foster children with special needs’ who are headed to independence.

As we have discussed, the decision to place out of home in the juvenile justice system often hinges on community safety issue as it particularly relates to parental ability to manage the behavioral risks of the child. To the extent that families need help to keep their children safely at home with supervision, eligibility for Medicaid services has the potential to offer that help under the conditions of a court order. The primary benefit of Title IV-E , then, is as a gateway to services.

Some advocates will argue – not without merit – that imposing foster care status for a condition of services is unwarranted. Right now, however, the juvenile justice population served in the most restrictive settings are children with serious emotional disturbance and/or children living in conditions of poverty that limit both parental and judicial option. A federal claiming strategy based in Title IV-E offers important protections for children who are already out-of-home and creates access to services.

*Objections.* There is substantial confusion about the ‘single agency’ requirement of

Title IV-E claiming for juvenile justice. This confusion arises because the State has jurisdiction in child welfare and counties have jurisdiction in juvenile justice. Therefore, it is the belief that the Illinois cannot claim Title IV-E funding to support local justice programs. However, from the federal perspective, the 'single system requirement' is about the judicial pathways into the system and governmental regulatory structures.

In order to create a reimbursable 'single agency' structure, Illinois must guarantee technical compliance with federal administrative requirements of Title IV-E. These requirements offer important client protections – judicial review, administrative case review, and good case management practice. This assurance to the federal authorities can be accomplished in a well-crafted intergovernmental agreement. In order to be acceptable to the State, the intergovernmental agreement must also minimize or eliminates the financial liability of the State. Both of these are possible.

There is no technical bar on the use of these funds. They can and should be made available to strengthen the juvenile justice programs. However, it is important to note that there are one real limitations in Title IV-E: neither public institutions of 25 or more beds nor any secured facility are eligible for federal reimbursement. Both provisions are intended to avoid the federal refinancing of large state–run juvenile institutions and to provide positive incentives to less restrictive and more community based settings.

## 2. Experience of Other Jurisdictions

Currently, there are four mixed payment arrangements in which counties/municipalities or states share responsibility for the local match to federal funds. These are: New York, Iowa, Texas, and California. A recent audit of the California system confirms the federal position.

In December 2000, The Office of the Inspector General of the U.S. Department of Health and Human Services released an "Audit of Protections Provided to Foster Care Children through the Juvenile Justice System in California." (A-09-99-00057) This audit of California's work did *not* find policy or finance problems. The audit, conducted in seven (7) county probation departments, found substantial non-compliance with the

administrative requirements of Title IV-E. These problems were with the quality of the work, not the qualification of the services for claiming.

Findings	Impacts on Children and Families
<p><b>Administrative Findings</b></p> <ul style="list-style-type: none"> <li>• No case plan was found in the record or the case plan did not meet state and federal minimum requirements.</li> <li>• Periodic reviews were a) not held, b) not timely, or c) did not meet state and federal requirements</li> <li>• Permanency hearings were a) not held, b) not timely, or c) did not meet state and federal requirements</li> </ul>	<p>The impacts on children and families when these protections are not in place include: parents unaware of the duration of treatment, parents unable to visit or attend family sessions due to poor communication and distance, placements not in compliance with specific terms of a court order, and placements with no treatment services. These protections are critical to uphold good practice; they are not simple bureaucratic ‘make work.’</p>
<p><b>Judicial Determination Findings</b></p> <ul style="list-style-type: none"> <li>• 27% of all cases (primarily in three of seven counties) did not contain documentation of judicial determination of the ‘child’s best interests’ and ‘reasonable efforts’</li> <li>• preprinted ‘blanket statements’ of determination or poorly substantiated evidence of individual determinations</li> </ul>	<p>The purpose of judicial determination is to provide independent assurance that the terms of the plan are in the child’s best interests. The impacts when these protections are not in place include: unnecessary removal of the child from the home, services to prevent removal are not offered, or services are not offered to achieve a return home.</p>

In California, these problems arose because of a nearly complete lack of State oversight. The California Department of Social Services (CDSS) did not monitor, issue policies, seek specific statutes or amend intergovernmental agreements to reflect state and federal requirements. Any of those actions – alone or in combination – had the potential to reduce or eliminate this set of problems. Further, California did not offer policy transmittals, training, or technical assistance to the court, probation or county social workers on the requirements of out-of-home placement. CDSS agreed with all of these audit findings and has instituted remedial actions in both oversight and training.

Clearly, these requirements reflect practices that should accompany any out-of-home placement. Illinois can avoid the problems experienced in California by crafting a

strategy that supports good practice supported by meaningful oversight and targeted training and technical assistance

### 3. State Issues and Concerns

Throughout the U.S., the relationships and interplay between states and counties shapes the local federal claiming strategy for juvenile justice. In Illinois, for example, counties were interested in using child welfare resources for non-secure detention and for diversion to substitute care as an alternative to detention. In several counties, informal agreements between the delinquency courts and child welfare professionals resulted in the State taking guardianship where there was no abuse or neglect. DCFS had always accepted a certain number of juvenile offenders directly from the delinquency calendar. However, over time referrals from the courts had increased and this population grew. A conservative estimate would be that 10% of the DCFS residential population were direct delinquency referrals.

Even under this informal arrangement, juvenile justice demand created a nearly \$18 million pressure on the DCFS budget. Also at that time, intake was growing, discharges were stalled, and welfare reform loomed on the horizon. When federal welfare reform was being drafted, the capping of related titles of the Social Security Act – Titles IV-E and IV-A and XIX -- were said to be imminent. With growing demand for child welfare services and a threatened cap, the estimate of \$10M for county juvenile justice resources was untenable. The child welfare system could not afford a large and continuing reduction in resources.

In that context, DCFS sought legislation to limit its responsibility in these cases; the statutory change precluded DCFS from taking custody any child whose arrest had prompted the placement decision. As a result, judges lost access to a historic baseline of 250 residential care beds for youthful offenders. The later *David B.* decision closed the back door to the child welfare system as an alternative to county juvenile justice interventions. This threat removed, the use of Title IV-E for juvenile justice should be reconsidered.

In working with DCFS to establish support new community alternatives for juvenile justice, the most important point to make is that Title IV-E is the critical gateway to services for children with serious emotional and behavioral problems. Secondly, DCFS residential providers – who are now under utilization pressures – would welcome a new purchaser in the market. Importantly, there is a new interest among child welfare providers in serving the juvenile justice population. This is documented in the new Child Welfare League of America' creation of a new Justice Division intended to support collaboration and integrated efforts between child welfare and juvenile justice. The Child Care Association of Illinois has also recently conducted training and advocacy with their members to strengthen the link between child welfare and juvenile justice. Judicial need and provider interest can be strengthened by intergovernmental agreements that include: the ability to agree with the court on the expected type and level of service, special training on the content domains of juvenile justice, and communication with the courts, especially good report writing.

In addition, we will need to we will need to address three issues in the context of drafting intergovernmental agreements:

- that Federal requirements for judicial determination and administrative practices will be scrupulously observed. Costs for training and oversight of the system will be assumed or shared by the county.
- that DCFS will not enter into any intergovernmental agreement where the county does not commit local funds for matching
- that funds are dedicated to new services, not refinancing existing services

We believe that DCFS will agree to pursue a strategy that is in the best interests of children, supports its provider base, can be operated at no additional cost to the state, and creates new community resources.

**Medicaid/Title XIX**

1. Federal Requirements

*Description.* Medicaid is a joint federal/state program which provides 50% reimbursement for allowable services, to eligible clients, by certified providers. There are two option – or ‘subprograms’ – in Medicaid which specifically suited to the multi-problem juvenile offender. These are: the Medicaid Rehab/Clinic Option (MRO) and the Targeted Case Management (TCM)options. Eligible services are:

Medicaid Rehabilitation/Clinic Options	Medicaid Targeted Case Management
Finances <b>services</b> , including	finances <b>case management</b> , including
<p>CLINIC SERVICES            Screening, diagnosis and assessment            Testing            Psychotherapy (ind, family, group)            Prescriptions and medication monitoring            Somatic treatments            Partial hospitalization            Emergency care            Consultation and education</p> <p>COMMUNITY SERVICES            day treatment            in-home services            collateral services            therapeutic foster care            early intervention services            crisis programs            some residential services</p>	<p>CASE MANAGEMENT ACTIVITIES            comprehensive assessment            plan of care development            locating/arranging/referring for services            ensuring that services are received            monitoring and reevaluating the plan of care            completing the case record            assisting in obtaining collateral services            advocacy            integration of services            assisting/training building community supports            24-hour crisis response            collateral contacts            problem-solving            transition linkage and referral            face-to-face contact with youth and collateral contacts</p>

*Benefits.* Through these MRO activities, counties can:

- increase service availability with rapid start-up using a pool of experienced providers who have already been certified by OMH or DCFS under Illinois Administrative Code: Rule 132
- track and improve services utilization patterns and accountability through contract management and billing

- enable judges, with clinical support, to define the types and intensity of services -- including a requirement of knowledge of the court's requirements -- for the juvenile justice population<sup>xvii</sup>
- use the assessment process within this Medicaid program to guide case disposition decisions and provide important prevalence data to quickly assess the potential for the application of Targeted Case Management to that particular county's juvenile justice population.

For counties, the primary benefit of TCM is that it creates a pool of funds that can be managed to support cross-system case management. Targeted Case Managers can be employees of either the public or private sector. As counties develop a rich array of alternative services, hands-on clinical management will improve results and reduce the burden on the courts for services coordination by:

- controlled access to the fuller array of services
- integrated care planning that crosses several systems, including schools
- improved sequencing of services utilization to improve effectiveness

*Conclusion:* There is nothing in Medicaid regulation or policy that bars an MRO claiming strategy. Implementation of the Targeted Case Management Option would require an amendment to the State Medicaid plan and subsequent HCFA approval. This is because Targeted Case Management is intended to finance cross-system case management and is intended for persons with complicated medical needs. Therefore, States are allowed to define discrete subclasses of the Medicaid population for TCM services. During the period when the amendment was in the approval process, we would be able to identify eligible youth in the population and, therefore, be able to develop clear cost/benefit statements for the Illinois Department of Public Aid on this option.

## 2. Experience of Other Jurisdictions

Medicaid has become an increasingly important part of financing health and behavioral health services for a variety of public sector clients. More than half of the child welfare systems now use Medicaid programs to deliver constitutionally required services to wards. In this application, new federal funds are used to create enhanced,

new services. Medicaid is also an important ingredient in funding health and behavioral health services in detention centers and prisons. In these settings, the potential bar to the use of these funds is the requirement for a 'certified provider.' There are several consulting firms which assist county detention and state correctional officials in designing systems which meet federal claiming requirements. In fact, the Illinois Department of Corrections has issued a Request for Proposals for this purpose. In this application, federal funds relieve budget pressures, but do not necessarily result in new services development.

## 2. State Issues and Concerns

In the Edgar Administration, Child welfare and mental health professionals believed that the infusion of Medicaid funding into traditional residential and community programs held the key to upgrading the clinical capacity of the child welfare system. In spring of 1989, Department of Children and Family Services, the Office of Mental Health Services, the Department of Public Aid and the provider community began to explore how Medicaid could be applied to State programs for children.

This work led to the creation of a new regulatory framework – Ill Administrative Code: Rule 132. This rule supplemented previous, inflexible Medicaid rules that failed to explore the greater community-based opportunities allowed in federal law. The implementation of Medicaid enhancements for foster care provided two important benefits. First, the state could match child welfare funds with federal funds to increase the total resources/services available to serve children with special needs. Rule 132 provided a way to leverage the state dollars for clinical services for children presenting increasingly complex clinical needs in both residential services and foster care. Secondly, Rule 132 established minimum standards for providers. Certification of providers (who chose to participate) required: restructured programs, additional and upgraded clinical staff, and rigorous clinical procedures.

As more and more residential facilities became Medicaid-certified in the early 1990s, pressures began to build on counties' juvenile justice budgets. Counties -- which for years used these same residential facilities -- now faced large increase in the per diem cost of placement. For example, in the Collar Counties, the historic placement

costs for 50 beds of residential care (at \$2.2M) were now 60% more expensive. And to complicate issues, Medicaid bars the negotiation of lower rates on a county basis. Further, Medicaid bars “cross subsidies of other programs” and insists that the State-established rate cannot be reduced for other payers. The county officials found their purchasing power sharply reduced.

The best example of the benefit of restructuring governmental financing is that the combination of child welfare funds (Title IV-E ) with the Medicaid (Rehab/Clinic Option) with a county match. This formula can reduce the county's share of residential care from \$209 (an average current rate) to \$104.50 per day at no additional cost to Illinois taxpayers. The use of child welfare funds as a platform Title IV-E alters both sides of the equation. It allows for 50% of residential care costs (placement and supervision costs) to be reimbursed through a federal claim. Most importantly foster care status extends automatic Medicaid eligibility. Therefore, counties can obtain a wide range of direct therapeutic and support services in either residential or community settings. These services and interventions can make a difference in juvenile justice outcomes for youth who might not otherwise be eligible for needed treatment.

As we have already discussed, Illinois' structured limitation of Title IV-E has had a largely adverse impact on juvenile justice programs. Secondly, the Illinois strategy to intensify the clinical capacity for wards of the State and other poor children at no State cost drove up the costs of care at the county level and led to additional unexpected pressures on the juvenile justice system. These two events combined exacerbated long standing disjoints between county and State responses to youthful offenders and further confused the technical issues of juvenile justice participation in federal programs. The primary cause of this confusion was speculation and planning for pending federal welfare reform that put State and county interests at loggerheads. This complicated set of transactions has never been fully and systematically explained. For some, this confusion contributed to the belief that there were insurmountable technical barriers to the juvenile justice system accessing federal financial participation. This is not the case. For example, an important control in the current system is the contractual limitation on provider services. At this time only DCFS and OMH are authorized to issue contracts for MRO services, but there is not reason this authority could not be expanded to include county governments.

The time is right to align these State and county interests and to implement sound financing for juvenile justice. Illinois has implemented welfare reform activities. At this time, there is no federal cap on Title IV-E. Illinois' Medicaid claims are well-within federal limits. Further, recent challenges to Medicaid programs may result in the loss of \$500M in federal revenue to Illinois. It is in the Administration's and the taxpayers' interest to recoup these funds. The leadership at the Department of Children and Family Services has demonstrated the effectiveness of Medicaid claiming as a clinical enhancement strategy and has proven ability to work with other state agencies and providers to make this system work.

## **IV. NEXT STEPS**

Illinois is well positioned to implement a federal claiming strategy. Recent epidemiological and services research supports the need for a broader array of judicial alternatives for disposition. Further, Judges' preferred dispositional alternatives are congruent with the services offered under these federal both Title IV-E and Medicaid. The Youth Campus' review of federal policy has found that there are no significant bars to implementing a comprehensive financing strategy.

The Jane Addams Juvenile Court Foundation has commissioned this policy analysis as the first step in a public process to build new community and residential alternatives for juvenile courts through a comprehensive financing strategy. The proposed strategy leverages already appropriated county funds by matching them with federal funds without expanding State liability. The use of federal financial participation – initially focusing on child welfare funds provided under Title IV-E – provides both the opportunity and the incentive for successful development of long-needed resources at the county-level.

The next step in this process is a summit meeting of state, county, and private sector leadership to review these materials and agree on a package of policy goals and political and strategies. With this agreement, Illinois can mount an organized, public/private advocacy effort to implement legislative and inter-governmental agreements and to create necessary administrative structures. This paper is addressed to policy leaders in juvenile justice to review both the options and the technical solutions.

Recommended members of the working group include:

Jane Addams Juvenile Court Foundation	Sheila Merry Hon. Joseph Schenider
John Howard Association/ Illinois Juvenile Justice Commission	Mike Mahoney
Child Care Association of Illinois	Marge Berglind
Illinois Collaboration on Youth	Dennis Murstein
Court Services Administrators Cook County DuPage County Peoria County Lake County	Mike Rohan John Bentley Steven P. Kossman TBN
Illinois Criminal Justice Information Authority	Candace Kane
Illinois Bar Association/Juvenile Committee	Mary McDermott
Northwestern University	Steve Drizin
Juvenile Justice Initiative	Betsy Clark
Cook County State's Attorney	Cathy Ryan
Annie E. Casey Foundation	Bart Lubow
Cook County Juvenile Court	Judge Heaston
Department of Children/Family Services	Jess McDonald and designee
Department of Health/Social Services	Anne Studzinski
Cook County Board	Tom Glaser or Donna Dunning
Legislator	Dart or Rauschenberg

This group can shape and validate a four-step course of action to which will create the required legislative, regulatory, and intergovernmental frameworks to benefit children, families, and court systems throughout Illinois.

To support this effort, the Jane Addams Juvenile Court Foundation has obtained the support of The Youth Campus to provide analytic and staff support to this effort. Joseph Loftus and Patricia Chesler will conduct activities in development, advocacy, and implementation, including:

<p><b>Development</b></p> <ol style="list-style-type: none"> <li>1. Research and analysis, including interviews</li> <li>2. Obtaining critical reviews of all drafts</li> <li>3. Convening and preparing materials for all meetings</li> </ol>	<p><b>Advocacy</b></p> <ol style="list-style-type: none"> <li>4. Discussions – with others -- with State policy leadership</li> <li>5. Development of support materials for State policy leadership (e.g., sample intergovernmental agreements and statutory/regulatory changes)</li> <li>6. Developing and delivering education materials for county policy leadership and private sector organizations on impacts of proposed changes.</li> </ol>
<p><b>Implementation</b></p> <ol style="list-style-type: none"> <li>7. Assessing the interest and need of individual counties in participating in new financing options for juvenile justice</li> <li>8. Providing technical support to interested counties on the technical requirements of participation (e.g., sample intergovernmental agreements, Medicaid certification, sample court orders, etc.)</li> <li>9. Preparing a recommended work plan and next steps for complete implementation at the County-level.</li> </ol>	

In order to implement new intergovernmental financing mechanisms at the county level, Illinois can:

1. pass enabling legislation and appropriation authority within the DCFS budget
2. make regulatory changes within Illinois Administrative Code
3. design and execute intergovernmental agreements
4. provide for new provider certification and client billing/reporting systems

Each of these steps is described below.

## 1. Legislative Education and Action

In order to implement a federal claiming strategy through County/State intergovernmental agreements, the Illinois Department of Children and Family Services (DCFS) would need enabling legislation and appropriation authority. This transaction is financial beneficial to the State and to Illinois taxpayers. It is neutral in terms of General Revenue Funds and returns substantial federal tax dollars to Illinois communities. The only potential opposition to legislation is from members of Illinois General Assembly who strongly hold that the Illinois Department of Children and Family Services should not expand its mandate. Therefore, DCFS cannot seek such legislation. However, if the legislation were carefully crafted to support State juvenile justice policy and the best interests of children and families, DCFS can prove a willing partner.

There are four components which should make this proposal attractive to the Illinois General Assembly: a) *financial benefits* to local citizens, b) shared interests of county governments in Cook, the Collar counties, and rural counties, and c) the research and experience demonstrating that specific approaches produce good outcomes, and d) requirements of current law. In addition, the clearest strategy for obtaining legislative support is based on the alignment of a broad set of interests through an understanding of *county government need*, support in the *research base*, and the will to fully implement *current Illinois law*.

## 2. Regulatory Changes within Illinois Administrative Code

The least difficult stage in the process of securing access to Medicaid services for adjudicated youth who are already Medicaid eligible according to Illinois' current criteria in Section 59 Illinois Administrative Code Part 132. This rule, in its current form, creates the basic framework of service, clinical process and management and was jointly drafted by DCFS and Office of Mental Health Services (then DMHDD) with substantial stakeholder input. The current provisions allow for the full range of services that counties might need to advance service development and improve outcomes.

While it is *not* necessary to revise this rule to allow counties to enter into intergovernmental agreements with the Department of Children and Family Services, it may be wise to codify the State's intent. Any desired change in the regulation should be undertaken early. As an amendment to a State regulation, the proposed change must be approved by the Joint Committee on Administrative Rules, and is subject to a review process that requires a minimum of at least five months. Further, because Rule 132 is promulgated by the Office of Mental Health Services/Illinois Department of Human Services, any amendment to the regulation must have the support of both agencies. The past success in joint development of the rule and the support of the Governor's Office will facilitate approval process.

It may be desirable at some point to make a technical amendment of the Medicaid (Title XIX) State Plan – the submission of the Department of Public Aid (DPA) for federal approval – to expand claiming options for youthful offenders. If this is the case, history suggests that DPA will continue its strong support for the Medicaid efforts of OMH and DCFS. Any technical amendment process should not delay the selection and/or certification of facilities.

### 3. Execution of Intergovernmental Agreements

With the state-level systems in place, the at the county level is executing an intergovernmental agreement which allows for Title IV-E eligibility and Medicaid claiming. From the county point of view, the program components of this agreement will require creating a court order that will stand the test of judicial determination of best interests, guardianship, licensing, administrative case review and other essential protections of the Title IV-E program. From the DCFS point of view – and with the above requirements met – the mechanisms for client enrollment, tracking, and data collection to support a Title IV-E claim are essential. Both sets of legal requirements can be easily met.

The more complicated set of transactions will be execution of agreements on a county-by-county basis. We are aware that DuPage, Lake, and Peoria Counties are experiencing specific difficulty in locating and financing juvenile justice programs within

their budgets. The alignment of interests between Cook and these counties is a powerful lever for change.

However, in implementation we suggest a phase-in strategy in which the first wave of participating counties is self-selected. The purpose of this method is to insure that the negotiation of the intergovernmental agreement is based upon a need expressed by the judiciary and supported by the county government. This will support a negotiation process which is sensitive to the Federal and State requirements for implementation of a program which mirrors the 'single agency program' requirement of Title IV-E. Secondly, we suggest that – to the extent possible – the initial participating counties include: Cook, collar counties, rural, and urban counties. This will form the basis of a standard, but flexible, framework for implementation in like areas.

#### 4. Provider Capacity Development and Reporting Systems

Once intergovernmental agreements are reached, counties will face the challenge of developing provider capacity and billing systems. Each of the participating counties will assess current youth mental health resources in their communities. This can include:

- lists of providers already certified by OMHS or the Department of Children and Family Services (DCFS) along with any specialized population service options. From this list, the county can identify providers specific to the needs of the juvenile justice. The analysis can also be used to identify gaps in service providers which may require specific action to bring on line for Medicaid (Title XIX claiming).
- services gaps in available residential and outpatient to determine the extent to which the county will require certification of other current service providers (The provider certification activity is undertaken by the provider; there is no demand on county resources for this activity. A brief outline of the provider certification process is included as Appendix A as a point of information for county officials.)
- the potential for specialized services options such as comprehensive assessment and case management -- like Targeted Case Management -- which could enhance intensive parole and other service programs

In addition, the Department of Children and Family Services will require a billing system that meets the requirements for submission to Public Aid. Both DCFS and OMHS use the same Medicaid Billing System, which can be readily adapted for county purposes.

## **V. SUMMARY**

A review of the research demonstrates that youth with serious emotional or behavioral problems are routinely involved with the juvenile justice system and that they tend to be served in the most restrictive and expensive systems. This research further demonstrates that there are both services designs and clinical interventions which produce good outcomes for these youth. There is no question that less expensive interventions that produce good outcomes are desirable. In addition to the humanitarian benefit, rehabilitation is – in the long term – a wise investment for Illinois governments.

The implementation of Illinois state statute on juvenile disposition is severely hampered by the lack of available treatment resources and the lack of services to support parental supervision. This is an issue of social justice tied to local economics.

A review of federal regulation and the experience of other states shows that there is no federal bar on accessing federal funds to finance expanded local services options for the juvenile justice population. However, there is history in Illinois – particularly in the context of earlier federal welfare reform proposals – which has curtailed a discussion of these options.

There is a knowledge base and a technology to design and implement a financing strategy for new community services by matching county funds with federal funds through the State's child welfare agency.

To achieve this goal DCFS would require legislative authority and appropriation. This group is best positioned to gain that legislative change. There are subsequent technical changes – in Administrative Rule, in crafting intergovernmental agreements, and in implementation – which would require an ongoing collaboration.

This paper provides a starting point for this critical public/private collaboration on behalf of Illinois children.

## **Appendix CONVENE LEADERSHIP**

### Suggested Agenda

- |  |                       |
|--|-----------------------|
| 1. Welcome and Introductions               | Hon. Joseph Schneider |
| 2. Purpose of the Meeting/Process Overview | Sheila Merry          |
| 3. Overview of Federal Financing           | Joe Loftus            |
| 4. Open Policy Discussion                  | Hon. Joseph Schneider |
| 5. Advocacy Action Discussion              | Sheila Merry          |
| 6. Other (you suggest)                     |                       |

## **Appendix A**

Both DCFS and OMH implement provider certification activities as required by Rule 132. Given that the platform for the financing strategy rests with DCFS, the provider certification activity may be lodged in that agency. The steps for provider certification and billing are summarized below as a point of information. These steps include:

- Application The regulations require that potential Title XIX providers submit an application for certification on forms or formats provided by the Department. The significant elements of the application require: (1) a contract with the Department, (2) identification and description of the of the Title XIX services to be provided, (3) the identification of the staffing pattern proposed, (4) a description of the policies required by the regulations and (5) identification of the facility(ies) where services will be provided. The Department must review the application within a specified time frame, and respond to the provider with an approval of the application or with a letter setting out the required corrective actions to bring the application into compliance. As a practical matter, providers may need supportive technical assistance to meet the requirements of the initial application. The initial certification is good for a period of one (1) year.
- On site verification visit An initial certification application can be approved through a desk review of the application materials from the provider. However, this certification must be verified through an on site visit within six (6) months of the initial certification approval date. This and subsequent on site visits should use standardized protocols to assure a thorough review of compliance, and can also include contract monitoring protocols. Following the on site visit, the Department must issue a letter continuing the certification with or without a notice of corrective action, depending on the results of the on site visit.
- Addition of sites or services In the initial certification, providers must specify the sites or locations being certified as well as the specific Rule 132 services that are included in the certification. It often happens that at a later date, the provider or the

Department wishes to add additional services or new sites. When this occurs, a request for certification of these additional sites or services must be submitted, reviewed and approved by the Department within established time frames. As with the initial certification, the Department will approve such requests if fully compliant with the regulations, or may require additional materials or other corrective actions to satisfy the regulations.

- Focus reviews Following certification of additional sites and services, the Department must conduct a follow up review to verify compliance with the desk review of the application, just as with the initial certification visit. The focus review can also be used as a follow up to corrective actions required in the initial or subsequent site visits testing compliance. As with other site reviews, findings must be issued in writing stating that the provider is in compliance or setting out corrective actions required. Specific time frames for Department and provider responses are specified in the regulations.
- Annual recertification Following the initial one-year certification, the Department is required to recertify providers. This does not required an application, but does require an on site visit, again using a standard protocol. The results of the annual recertification visit must be issued in writing within specific time frames, and any required corrective actions set forth in this notice. Once the provider is found to be fully compliant, they do not require additional on site compliance visits for an additional two (2) years. This does not preclude the Department from conducting focus reviews or contract monitoring visits as needed.
- Three year recertification At the end of the third year of certification, the Department must recertify providers. This three (3) year certification does not require an application, but again requires an on site visit to assure compliance. As usual, findings must be issued in writing noting the status of the provider's compliance and any needed corrective action. Once determined to be fully compliant, the provider is issued an additional three-year certification.

- Suspension, withdrawal or denial of certification Rule 132 outlines the process require in the event the Department needs to suspend or deny certification for noncompliance, or in the event that the provider wishes to withdraw their certification under Title XIX. While withdrawal of certification is more common than suspension or denial, the Department is prepared to utilize all of these options to achieve compliance.
- Contracting As required in the regulations, the Department must hold contracts with any service providers that they wish to certify.
- Contract conversion In order to claim for Medicaid reimbursement, there are unit rates for both residential and outpatient services. These rates can be different for each provider, but must conform to standardized rate setting methodologies. The process of contract conversion for Medicaid affords an opportunity to enhance the staffing pattern, range of services, or court -related activities.

## **V. WORK PLAN**

### Planning and Implementation

<b>Objective</b>	<b>Tasks</b>	<b>TYC Partner</b>
Confirm goals and work plan	1. Convene a small group of key leaders to review the work plan and specifically to identify issues which must be addressed in the research and policy recommendations	JAJCF/TYC
Conduct research and analysis	1. Review relevant federal, state, and county statute and administrative rules 2. Explore strategies of other states and jurisdictions for financing juvenile justice services 3. Discuss current needs and barriers with public officials 4. Draft policy white paper which includes policy, program and cost information	TYC with in working group CWLA
Develop consensus legislative language and advocacy strategy	1. Draft policy white paper 2. Develop list of key advocate participants 3. Develop agenda and invitations 4. Convene policy and strategy meeting 5. Confirm consensus in minutes	Developer invitations agenda will with JAJCF
Implement advocacy strategy	1. Prepare fact sheets 2. Create central location for coordination of efforts 3. Provide answers to specific questions by administrative and legislative policy makers (on-going)	JAJCF will review and on all preparation materials.

Objective	Task	TYC Partne
Assess interest/need of counties in participating in federal financial participation	<ol style="list-style-type: none"> <li>1. Develop model for cost effectiveness</li> <li>2. Develop letter/explanation of cost and benefits to counties</li> <li>3. Conduct survey of interest and tabulate</li> </ol>	JAJCF will r review and c on all prepa materials.
Provide technical assistance to counties for implementation	<ol style="list-style-type: none"> <li>1. Provide sample intergovernmental agreement</li> <li>2. Provide Medicaid certification technical assistance, as needed</li> <li>3. Assist courts in developing referral data base</li> <li>4. Arrange consultation on clinical assessment – if needed – from Illinois public universities.</li> </ol>	TYC will wo DCFS, OMF others on th materials

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<sup>i</sup> OJJDP outlines **core intervention strategies**: 1) a system which progressively decreases from an initial high-level of external control to increased youth responsibility and control; 2) an individualized case plan which is continuously monitored; 3) attention to developing attachments between the youth and his peers, adults, and other community groups and institutions; 4) active teaching of social/interpersonal skills; 5) development of life skills; 6) education and employment opportunities which offer short and long term rewards; 7) risk management; and 8) reliable rewards and sanctions. (p. 9. OJJDP)

<sup>ii</sup> (p.1, Palmer in “Martinson Revisited”) and p.2, Andrews meta-analysis of high risk offenders)

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<sup>iii</sup> *Juvenile Crime and Justice System Activities in Illinois: An Overview of Trends*. The Illinois Juvenile Justice Commission. The Research and Analysis Unit of the Illinois Criminal Justice Information Authority. June 2000. Pp. i – iii.

<sup>iv</sup> *Child Services: Social Policy, Research, and Practice*. “Mental Health Service Needs of Juvenile Offenders: A comparison of detention, incarceration, and treatment settings.” Northwestern University and the National Council on Crime and Delinquency. (in press)

<sup>v</sup> Otto, Greenstein, Johnson, et.al.

<sup>vi</sup> (p.1, Palmer in “Martinson Revisited”)

– <sup>vii</sup> . (p.2, Andrews meta-analysis of high risk offenders)

<sup>viii</sup> (p. 9. OJJDP)

1) <sup>ix</sup> (p.6, Altschuler, *Perspectives*, Summer, 1995.)

<sup>x</sup> (p.7, NCCD)

<sup>xi</sup> (p.7, NCCD)

<sup>xii</sup> (p.11, Berg and Miller).

<sup>xiii</sup> (p.10, Clark, *Journal for Juvenile Justice and Detention Services*)

<sup>xiv</sup> *Juvenile Crime and Justice System Activities in Illinois: An Overview of Trends*. Prepared for the Illinois Juvenile Justice Commission by the Illinois Criminal Justice Authority. June 2000. p. 22

<sup>xv</sup> op. cit., p. 7

<sup>xvi</sup> Lyons study, p7

<sup>xvii</sup> Recent findings of the Cook County Clinical Evaluation and Services Initiative propose a court clinic which could serve as a model for the guidance and appropriate use of community services. This clinic’s assessment services could be reimbursable under the MCO option.